KEVIN V. RYAN (CSBN 118321)
United States Attorney

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

| | |
|---|---|
| UNITED STATES OF AMERICA,<br><br>Plaintiff,<br><br>v.<br><br>DILBAGH S. CHATTHA,<br><br>Defendant. | No.<br><br>VIOLATIONS: 18 U.S.C. § 1347 – Health Care Fraud; and 18 U.S.C. § 1341 – Mail Fraud<br><br>OAKLAND VENUE |

# INDICTMENT

The Grand Jury charges:

## INTRODUCTION

At all times material to this Indictment:

### A. THE DEFENDANT

1. CHATTHA was a medical physician licensed to practice medicine in the State of California. CHATTHA maintained a medical office at 1860 Mowry Avenue, Suite 303, Deccan Pacific Plaza, Fremont, California.

**B. THE HEALTH CARE BENEFIT PROGRAM**

2. CHATTHA participated as a provider of medical benefits, items, and services to patients covered by various health care benefit programs, including the Federal Employees Compensation Act (FECA), 5 U.S.C. § 8101 et seq. which provides for the payment of disability compensation benefits for federal civilian employees of the United States government who incur on-the-job injuries or employment-related diseases or illnesses. The FECA also provides for the payment of all related medical costs. The United States Department of Labor, Office of Workers' Compensation Programs (DOL-OWCP) administers the FECA. The patients covered by FECA are called "claimants." The physicians who see and treat program claimants are called "providers." As administered by the DOL-OWCP, the FECA fits the definition of a health care benefit program, as defined by Title 18, United States Code, Section 24(b) which defines "health care benefit program" as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."

**C. THE CLAIM FOR REIMBURSEMENT PROCESS**

3. In administering the FECA, the DOL-OWCP pays providers based on claims for reimbursement filed by the provider following his or her provision of medical benefits, items, or services to a claimant. Typically, providers submit a form called a HCFA 1500 to the DOL-OWCP document their claims for reimbursement under the FECA. CHATTHA used HCFA 1500 forms.

4. CHATTHA submitted, or caused his staff to submit, his procedure notes to the DOL-OWCP as backup or support for his claims for reimbursement. CHATTHA dictated most of his procedure notes simultaneous to his visits with patients. CHATTHA directed his billing staff to prepare the claims for reimbursement and submit them to the DOL-OWCP for payment.

**D. BILLING CODES AND PROCEDURES**

5. Providers must use codes established by the American Medical Association (AMA) to identify each procedure and service for which the provider seeks reimbursement. The AMA calls the billing codes the "Physician's Current Procedural Terminology" or "s" or "billing codes," (hereafter "CPT codes"). Providers must choose the CPT code that most accurately and completely identifies the procedures performed and services they perform or provide. Pursuant to the language in the HCFA 1500 form, providers certify the accuracy of their claims for reimbursement at the time they submit them for payment. Most often, the DOL-OWCP relies solely on the information providers put in the HCFA 1500 form when approving claims for reimbursement. Sometimes, however, the health care benefit program may ask a provider for their procedure notes or similar documentation before paying a claim.

6. CHATTHA was familiar with and used the CPT billing codes, and directed his staff to prepare HCFA 1500 forms using those codes. At issue here, are physician services known as office visits and special reports.

**E. OFFICE VISITS**

7. The CPT code addresses billing guidelines for physician services in a section entitled "Evaluation and Management (E/M) Services." The E/M section itself is divided into broad categories such as office visits, hospital visits, and consultations. These broad categories are then divided into subcategories. The E/M section on office visits sets forth billing guidelines according to a patient's status as "new or established."

8. The CPT Manual states that "a new patient is one who has not received any professional services from the physician within the past three years." The CPT Manual states that "an established patient is one who has received professional services from a physician within the past three years." The counts in this Indictment relate solely to established patients.

9. E/M classifications are material because physicians get paid depending on

several factors relating to his or her performance or supervision of patient services. Because services provided by a physician vary based on the nature of the physician's work, the CPT Manual requires physicians to document specific information regarding their own or their staffs' encounters with patients. The CPT Manual details the level and nature of the documentation required of the physician to bill the different levels of office visits.

10. The CPT Manual recognizes five levels of service depending upon an evaluation of the following seven factors: (1) medical history; (2) medical examination; (3) medical decision making; (4) counseling; (5) coordination of care; (6) nature of presenting problem; and (7) time. Factors (1) through (3) constitute key components in selecting the level of service. Factors (4) through (6) are considered contributory factors in the majority of office visits, although it is not required that these services be provided at each patient office visit. Factor (7), time, is not considered to be a key or controlling factor in selecting the level of service unless counseling and/or coordination of care constitutes more than 50% of the time spent by the physician/patient and/or family encounter.

11. The CPT Manual lists the following five billing codes for office visits:

**Level One – 99211** is an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal, and typically five minutes are spent performing or supervising these services.

**Level Two – 99212** is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a problem focused history; a problem focused examination ; and/or straightforward medical decision making. Usually, the presenting problems are self-limited or minor, and typically physicians spend ten minutes face-to-face with the patient and/or family.

**Level Three – 99213** is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: an expanded problem focused history; an expanded problem focused examination; and/or medical decision making of low complexity. Usually, the presenting problems are of low to moderate severity, and typically physicians spend fifteen minutes face-to-face with the patient and/or family.

**Level Four – 99214** is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a detailed history; a detailed examination; and/or medical

decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity, and typically physicians spend twenty-five minutes face-to-face with the patient and/or family.

**Level Five – 99215** is an office or other outpatient visit for the evaluation and management of an established patient which requires at least two of the following three key components: a comprehensive history; a comprehensive examination; and/or medical decision making of high complexity. Usually, the presenting problems are of moderate to high severity, and typically physicians spend forty minutes face-to-face with the patient and/or family.

12. Throughout the period covered by the Indictment, CHATTHA billed for Office Visits at Level Five under CPT code 99215 routinely.

## F. SPECIAL REPORTS

13. The CPT code 99080 permits the submission of a "special report" for an unlisted service or one that is unusual, variable, or new. The purpose of the "special report" is to demonstrate the medical appropriateness of the service. Pertinent information includes an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. "Special reports" include more than the information conveyed in the usual medical communications or standard reporting form. Throughout the period covered by the Indictment, CHATTHA billed for Special Reports under CPT code 99080 routinely.

## G. THE SCHEME TO DEFRAUD

14. Beginning at least as early as January 1, 1999 and continuing through at least in or about August 31, 2003, in the Northern District of California and elsewhere, CHATTHA knowingly devised and intended to devise a scheme

(1) to defraud the health care benefit program conducted under the FECA and administered by the DOL-OWCP, and

(2) to obtain, by means of false and fraudulent pretenses, representations, and promises, money belonging to and under the care, custody, and control of these health

care benefit programs.

15. CHATTHA accomplished this scheme by mailing or electronically transferring claims for reimbursement that included health care billing forms containing false and fraudulent information to health care benefit programs to obtain, and attempt to obtain, payment for the billed items. In this regard, CHATTHA:

a. Submitted claims containing billing codes in support of requests for payment for Level Five office visits under CPT code 99215, knowing that he had not performed services at the level set forth in the CPT Manual for CPT code 99215 and that he did not submit the documentation necessary to justify billing for a Level Five office visit under CPT code 99215;

b. Submitted claims containing billing codes in support of requests for payment for "Special Reports" under CPT code 99080, falsely asserting that he had performed an unlisted service or one that was unusual, variable, or new and met the other criteria set forth in the CPT Manual. In truth and in fact, however, as CHATTHA then well knew, the services he provided to his patients did not support his claim for reimbursement for a "Special Report" and did not meet the criteria under CPT code 99080. Specifically, CHATTHA simply supplied his diagnostic notes in the form of a progress report and then submitted a claim for reimbursement for a "Special Report."

**H. TOTAL AMOUNT OF FRAUDULENT BILLINGS**

16. During the period January 1, 1999 until August 31, 2003, CHATTHA billed, or caused his staff to submit bills, to the DOL-OWCP, the bills including, the amounts, procedures, and services listed below, which CHATTHA did not render to his patients in the manner required by established billing and medical guidelines:

| **SERVICE CLAIMED** | **AMOUNT BILLED** | **AMOUNT ALLOWABLE** | **AMOUNT OF FRAUD** |
|---|---|---|---|
| 99215 | $ 162,820 | $ 60,627 | $ 102,192 |
| 99080 | $ 66,811 | $ 0 | $ 66,811 |
| **TOTALS** | $ 229,631 | $ 60,627 | $ 169,003 |

**COUNTS ONE through TEN:** (18 U.S.C. § 1347 (Health Care Fraud)

1. The allegations contained in the Introduction to this Indictment, Sections A through H, are incorporated herein as if fully set forth in each of Counts One through Ten as constituting the scheme to defraud and to obtain money from the DOL-OWCP as identified below in Counts 1 through 10, by means of false and fraudulent pretenses, representations, and promises, in connection with the delivery and payment for health care benefits, items, and services.

2. On or about each date set forth below in Counts 1 through 10, in the Northern District of California and elsewhere, CHATTHA, for the purpose of executing and attempting to execute the above scheme and artifice to defraud, and to obtain money by means of false and fraudulent pretenses, representations, and promises, knowingly submitted and caused to be submitted to the DOL-OWCP the claims for payment described below in each count in connection with the delivery of and payment for health care benefits, items, and services:

| COUNT | PATIENT | PAY DATE | BILLING CODE |
|---|---|---|---|
| ONE | Gurdarshan S. | 6/29/00 | 99215, 99080 |
| TWO | Avtar S. | 10/5/00 | 99215, 99080 |
| THREE | Gurmail B. | 4/5/01 | 99215, 99080 |
| FOUR | Estella T. | 10/18/01 | 99215, 99080 |
| FIVE | Lakhbir S. | 11/1/01 | 99215, 99080 |
| SIX | Lakhbir S. | 6/13/02 | 99215, 99080 |
| SEVEN | Gurmail B. | 8/22/02 | 99215, 99080 |
| EIGHT | Avtar S. | 10/3/02 | 99215, 99080 |
| NINE | Estella T. | 2/27/03 | 99215, 99080 |
| TEN | Gurdarshan S. | 6/12/03 | 99215, 99080 |

All in violation of 18 U.S.C. § 1347.

**COUNTS 11 through 20**: (18 U.S.C. § 1341 (Mail Fraud))

1. The allegations contained in the Introduction, Sections A through H, to this Indictment are realleged as if fully set forth in each of Counts Eleven through Twenty as

forming CHATTHA's scheme to defraud in connection with the delivery of or payment for health care benefits, items, and services.

2. On or about the dates listed below in Counts 11 through 20, in the Northern District of California and elsewhere, CHATTHA, did, for the purpose of executing the scheme, knowingly cause United States Treasury checks described below in Counts Eleven through Twenty to be sent and delivered by the United States Postal Service, each mailing constituting a separate and distinct violation of 18 U.S.C. §1341.

| **COUNT** | **PATIENT** | **PAY DATE** |
|---|---|---|
| ELEVEN | Gurdarshan S. | 6/29/00 |
| TWELVE | Avtar S. | 10/5/00 |
| THIRTEEN | Gurmail B. | 4/5/01 |
| FOURTEEN | Estella T. | 10/18/01 |
| FIFTEEN | Lakhbir S. | 11/1/01 |
| SIXTEEN | Lakhbir S. | 6/13/02 |
| SEVENTEEN | Gurmail B. | 8/22/02 |
| EIGHTEEN | Avtar S. | 10/3/02 |
| NINETEEN | Estella T. | 2/27/03 |
| TWENTY | Gurdarshan S. | 6/12/03 |

DATED: _____

A TRUE BILL.

_____
FOREPERSON

KEVIN V. RYAN
United States Attorney

_____
CHARLES BEN BURCH
Acting Chief, Oakland Branch

(App'd as to form: _____)
AUSA Davis